Nebraska Department of Health & Human Services
Regulation & Licensure, Credentialing Division
PO Box 94986 Lincoln NE 68509-4986
www.hhs.state.ne.us./crl/nursing/nursingindex.htm
(402) 471-2666 or fax (402) 471-1066

Application for **Reinstatement of Nursing License** from Inactive or Lapsed Status

Total Fees Due:

Name	First	Middle	Last
Address	Street/PO/Route		
	City	State	Zip
Social Security Number			
Date of Birth		Place of Birth	
License Type		License Number	

I declare that my primary state of residence is _____. This state is referred to as my home state under the Nurse Licensure Compact and means that it is my declared fixed permanent and principal home for legal purposes and is my domicile. Indicators of a domicile include, but are not limited to, where real property is located, where the person pays taxes, votes, is licensed to operate a motor vehicle, etc. If you indicated another compact state as your primary state of residence, but will be moving to Nebraska and declaring Nebraska as your primary state of residence, please indicate: YES ❑ and date_____.

List all other States where you have been or are currently licensed.		
	YES	NO
Has your nursing license in any state ever been disciplined for any reason?		
Is there any pending disciplinary action or complaint investigation regarding any health care license?		
If yes, name State and attach letter of explanation and dates.		
Have you ever been convicted of any offense other than a minor traffic violation?		
If yes, attach court records and disposition.		
Are there any pending misdemeanor/felony charges/investigation?		
If yes, attach letter and give dates, explanation and disposition.		

Please indicate most recent nursing employment:

Dates			
Institution/Setting			
	Street/PO/Route		
	City	State	Zip
Telephone Number		Position Number	

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State of _____)
County of _____)

I, _____ being duly sworn, say that I am the person referred to in this application for licensure in the State of Nebraska, that the statements herein contained are true to the best of my knowledge and belief and that I have read and understand the affidavit.

_____
Legal Signature of Applicant

NEBRASKA STATE BOARD OF NURSING
LICENSE REQUIREMENT DOCUMENTATION FORM
FOR REINSTATEMENT

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SECTION A.			
Name	First	Middle	Last
Address	Street/PO/Route		
	City	State	Zip
Day Time Phone		Social Security Number	

SECTION B.	
In order to obtain a Nebraska Nurse License, you must meet one of the following criteria. **Check the one you meet.**	
❑ I	500 hours Nursing Practice during the past five (5) years and 20 contact hours of continuing education during the past two (2) years. Complete sections C, D, and F.
❑ II	Graduated from a Board-approved **nursing** education program within the previous two (2) years. Complete sections E and F.
❑ III	Graduated from a Board-approved **nursing** education program longer than two (2) years, but less than five (5) years, and completion of 20 contact hours of continuing education during the past two (2) years. Complete sections D, E, and F.
❑ IV	Completion of a Board approved refresher course or an approved review course of study consisting of a minimum of 75 contact hours within the previous (5) five years. Complete sections D and F. **If enrolled or enrolling in a refresher course**, please note that you will need a temporary refresher license to do the clinical portion of that program. We will need your application, fee, and a letter of enrollment from your refresher program, as well as a letter from the program listing your beginning and ending clinical dates in order to issue the temporary license. Your permanent license will not be issued\reinstated until the refresher course is successfully completed.

SECTION C. Nursing Practice: INSTRUCTIONS: Record nursing practice from November 1 through October 31 for the five calendar years immediately preceding the renewal period for which the required license will be effective.

Employment Date		**Place of Employment Institution or Agency**	**Address of Employment City/State**	**# of Hrs. Worked**
Begin	**End**			

SECTION D: INSERVICE/CONTINUING EDUCATION. REPORT IN CONTACT HOURS ONLY.

No more than twenty percent of required continuing education hours (4 hours of the required 20 hours) shall be accumulated from Cardiopulmonary Resuscitation, Basic Life Support. 10 of the 20 contact hours must be peer reviewed by an organization given authority to approve continuing education. If you are enrolling in a board approved refresher course please note the date you started the course, the refresher course you enrolled in and the city and state the refresher course is located in.

DATE(S) MONTH/DAY/YEAR	AGENCY/PROVIDER	CITY AND STATE	TITLE and Topic if not evident from title (Do not use abbreviations)	Was this an independent/ home study course? NO	YES	Contact hours

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Section E: Graduation from a Nursing program within the last two (2) years, **or** graduated from a nursing program longer than two years, but within the past five years previous to the renewal period in which applied with an additional twenty (20) contact hours of continuing education within the last two years previous to the renewal period.

_____ _____ _____

Name of Nursing Program City/ State Degree/Diploma Year of Graduation

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Section F: Affidavit

State of _____, County of _____ I _____ Being duly sworn, say that I am the person referred to in this Record of Licensure, that the statements herein contained are true to the best of my knowledge and belief, and that I have read and understand the affidavit.

_____

Legal Signature of Applicant Date

Nebraska Department of Health & Human Services System
Regulation & Licensure, Credentialing Division
PO Box 94986
Lincoln, NE 68509-4986
402-471-4376 or fax 402-471-1066

Affidavit of Practice/Non-Practice

You must complete the following:

_____ I **have not** practiced nursing (except under the provisions of the Nurse Licensure Compact) ***in Nebraska*** prior to the date my license was reinstated (or my refresher course temporary permit was issued).

_____ I **have** practiced nursing in Nebraska prior to the reinstatement of my license (or prior to the date my refresher course temporary permit was issued) and without proper authority under the Nurse Licensure Compact.

The actual number of partial or whole days that I practiced without authority is _____.

If you have practiced nursing without a license/temporary permit or proper authority under the Nurse Licensure Compact, you will be required to pay an administrative penalty fee of $10 for each day you practiced up to a maximum of $1,000. You may enclose any penalty due with this form. If you do not enclose the penalty you will receive a Notice of Administrative Assessment and you will be required to pay the penalty at that time.

Employer Information:

_____
Name

_____
Address

_____
Telephone Number

Personal Information:

Print Your Name:_____ Your License #: _____

Daytime Phone Number: _____

Affidavit:

State of _____ County of _____, I _____ being duly sworn, say that I am the person referred to in this affidavit, that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

_____ _____
Legal Signature of Applicant Date